

Appendixes

Appendix A: State Quitline Information[†]

State (Adult Smoking Prevalence*)	Date Service Began	Language Services ^{††}	Primary Contractor	Quitline Contact Information
Alaska (29.4%)	January 2002	None	Providence Alaska Medical Center	1-888-842-QUIT (7848)
Arizona (23.5%)	January 1995	Spanish	University of Arizona	1-800-556-6222 E-mail: ashline1@u.arizona.edu http://www.ashline.org
Arkansas (26.3%)	January 2003	Spanish	Mayo Clinic Foundation	1-866-NOW-QUIT (669-7848) http://www.stampoutsmoking.com
California (16.4%)	August 1992	Cantonese, Korean, Mandarin, Spanish, Vietnamese	University of California, San Diego	1-800-NO-BUTTS (672-8887) 1-800-45-NO-FUME (456-6386) (Spanish) 1-800-838-8917 (Mandarin & Cantonese) 1-800-778-8440 (Vietnamese) 1-800-556-5564 (Korean) 1-800-844-CHEW (2439) (Smokeless) TDD: 1-800-933-4833 E-mail: cshoutreach@ucsd.edu http://www.californiasmokershelpline.org
Colorado (20.4%)	October 2001	Spanish	National Jewish Medical and Research Center	1-800-639-QUIT (7848) TTY: 1-800-659-2656 http://www.co.quitnet.com
Connecticut (19.5%)	November 2001	Spanish, Telephone Translation Service	United Way of Connecticut Infoline in partnership with Hartford Hospital	1-866-END-HABIT (363-4224) E-mail: quitline@ctunitedway.org http://www.ctquitline.org
Delaware (24.7%)	February 2001	Spanish, AT&T Language Line	American Cancer Society	1-866-409-1858 http://www.state.de.us/dhss/dph/dpc/quitline.html
District of Columbia (20.4%)	December 2003	Spanish	American Legacy Foundation	1-800-399-5589 http://www.americanlegacy.org
Florida (22.1%)	December 2001	Spanish, Haitian-Creole	American Cancer Society	1-877-U-CAN-NOW (822-6669) TTY: 1-866-228-4327
Georgia (23.3%)	September 2001	Spanish, AT&T Language Line	Center for Health Promotion, Inc.	1-877-270-STOP (7867) 1-877-2NO-FUME (266-3863) (Spanish) TTY: 1-877-777-6534 E-mail: gatups@aol.com http://www.unitegeorgia.com/resources/

[†] Compiled by Center for Tobacco Cessation, updated December 2003.
Telephone numbers and Web sites are subject to change without notice.

* Estimates of current adult smoking prevalence for each state are from the 2002 Behavioral Risk Factor Surveillance System. Centers for Disease Control and Prevention. State-specific prevalence of current cigarette smoking among adults, and policies and attitudes about secondhand smoke—United States, 2002. *Morbidity and Mortality Weekly Report* 2004;52(53):1277–1280.

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Illinois (22.9%)	1999	Spanish	American Lung Association	1-866-QUIT-YES (784-8937) http://www.idph.state.il.us/TobaccoWebSite/ quitsmoking.htm
Iowa (23.1%)	May 2001	Spanish	University of Iowa, Iowa Tobacco Research Center	1-866-U-CAN-TRY (822-6879) http://www.quitlineiowa.org
Kansas (22.1%)	October 2003	Spanish, Vietnamese	Wellplace (Pioneer Behavioral Health)	1-866-KAN-STOP (526-7867)
Louisiana (23.9%)	1999	N/A	Tobacco Control Resource Center	1-800-LUNG-USA (586-4872)
Maine (23.6%)	August 2001	None	Center for Tobacco Independence	1-800-207-1230 TTY: 1-800-457-1220
Massachusetts (19.0%)	July 1994	Portuguese, Spanish, AT&T Language Line	JSI Research and Training Institute, Inc.	1-800-TRY-TO-STOP (879-8678) 1-800-8-DEJALO (833-5256) TDD: 1-800-833-1477 E-mail: trytostop@trytostop.org http://www.trytostop.org
Michigan (24.2%)	October 2003	None	Leade Health	1-800-480-7848
Minnesota (21.7%)	April 2001	Spanish, AT&T Language Line	Center for Health Promotion, Inc.	1-877-270-STOP (7867) 1-877-2NO-FUME (266-3863) (Spanish) TTY: 1-877-777-6534 http://www.mpaat.org
Mississippi (27.4%)	September 1999	Spanish	Information and Quality Healthcare	1-800-244-9100 1-877-487-2228 http://www.quitlinems.com
Nebraska (22.8%)	June 2002	Korean, Spanish, Vietnamese	Wellplace (Pioneer Development and Support)	1-866-632-7848
Nevada (26.0%)	2001	Spanish, Tagalog	University of Nevada School of Medicine	1-888-866-6642 702-877-0684 (Las Vegas only)

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New Hampshire (23.2%)	August 2002	Portuguese, Spanish, AT&T Language Line	JSI Research and Training Institute, Inc.	1-800-TRY-TO-STOP 1-800-8-DEJALO (833-5256) TDD: 1-800-833-1477 E-mail: trytostop@trytostop.org http://www.trytostop.org
New Jersey (19.1%)	October 1999	Spanish, AT&T Language Line	Mayo Clinic	1-866-NJSTOPS TTY: 1-866-257-2971 http://www.nj.quitnet.com
New Mexico (21.2%)	January 2001	Spanish	NCI's Cancer Information Service	1-877-44U-QUIT http://www.thestink.org
New York (22.4%)	January 2000	AT&T Language Line	Roswell Park Cancer Institute	1-866-NY-QUITS (697-8487) TTY: 1-800-280-1213 1-866-293-1796 (New York City Medicaid) E-mail: Quitsite@Roswellpark.org http://www.nysmokefree.com
North Carolina (26.4%)	July 2003	Spanish	NCI's Cancer Information Service	1-877-44U-QUIT 1-866-66-START http://www.smokefree.gov
Ohio (26.6%)	August 2003	Spanish	National Jewish Medical and Research Center	1-800-934-4840 TTY: 1-800-229-2182 http://www.standohio.org
Oklahoma (26.7%)	August 2003	Spanish, AT&T Language Line	Center for Health Promotion, Inc.	1-866-748-2436
Oregon (22.4%)	November 1998	Spanish, AT&T Language Line	Center for Health Promotion, Inc.	1-877-270-STOP (7867) TTY: 1-877-777-6534 http://www.oregonquitline.org
Pennsylvania (24.6%)	June 2002	Spanish, Telephone Translation	American Cancer Society	1-877-724-1090 TTY: 1-866-228-4327
Rhode Island (22.5%)	April 2002	Spanish, AT&T Language Line	JSI Research and Training Institute, Inc.	1-800-TRY-TO-STOP (879-8678) 1-800-8-DEJALO (833-5256) (Spanish/Portuguese) TDD: 1-800-833-1477 http://www.trytostop.org

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State (Adult Smoking Prevalence*)	Date Service Began	Language Services ^{††}	Primary Contractor	Quitline Contact Information
South Dakota (22.6%)	January 2002	AT&T Language Line	American Cancer Society	1-866-SD-QUITS (737-8487) TTY: 1-866-228-4327
Tennessee (21.2%)	January 2001	Spanish	NCI's Cancer Information Service	1-877-44U-QUIT http://www.thestink.org
Texas (22.9%)	September 2001	Spanish, AT&T Language Line	American Cancer Society	1-877-YES-QUIT (937-7848) TTY: 1-866-228-4327
Utah (12.7%)	September 2001	Spanish	Center for Health Promotion, Inc.	1-888-567-TRUTH (8788) 1-877-2NO-FUME (266-3863) (Spanish) TDD: 1-877-777-6534 http://www.tobaccofreeutah.org
Vermont (21.2%)	February 2001	AT&T Language Line	American Cancer Society	1-877-YES-QUIT (937-7848) TTY: 1-866-228-4327 http://www.healthyvermonters.info/hi/tobacco/tobacco.shtml
Washington (21.5%)	November 2000	AT&T Language Line	Center for Health Promotion, Inc.	1-877-270-STOP (7867) 1-877-2NO-FUME (266-3863) (Spanish) TTY: 1-877-777-6534 http://www.quitline.com
West Virginia (28.4%)	2000	Spanish	Partners In Corporate Health	1-877-966-8784 http://www.ynotquit.com
Wisconsin (23.4%)	May 2001	AT&T Language Line	Center for Health Promotion, Inc.	1-877-270-STOP (7867) 1-877-2NO-FUME (266-3863) (Spanish) TTY: 1-877-777-6534 http://www.ctri.wisc.edu/sub_dept/quit_line/out_quitline.html
Wyoming (23.7%)	October 2003	Spanish, AT&T Language Line	Mayo Clinic	1-866-WYO-QUIT TDD: 1-866-257-2971 http://wy.quitnet.com

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* Estimates of current adult smoking prevalence for each state are from the 2002 Behavioral Risk Factor Surveillance System. Centers for Disease Control and Prevention. State-specific prevalence of current cigarette smoking among adults, and policies and attitudes about secondhand smoke—United States, 2002. *Morbidity and Mortality Weekly Report* 2004;52(53):1277–1280.

^{††} In addition to English.

Appendix B: Vendors Providing Quitline Services to States

Note: This list is intended to serve as a directory of vendors known to CDC/OSH as of December 2003 and not as an endorsement for a particular vendor.[†]

Organization	Contact Information	Web Address
American Cancer Society	1599 Clifton Road, NE Atlanta, GA 30329 Phone: 404-327-6414	http://www.cancer.org
American Lung Association	3000 Kelly Lane Springfield, IL 62707 Phone: 217-787-5864 Fax: 217-787-5916	http://www.lungusa.org
Arizona College of Public Health	P.O. Box 210482 Tucson, AZ 85721-0482 Phone: 520-318-7212 x203 Fax: 520-318-7222	http://www.nicnet.org
The Center for Health Promotion, Inc.*	12401 East Marginal Way South Tukwila, WA 98186 Phone: 206-988-7901	http://www.ghchp.com
I.Q.H. Information and Quality Healthcare	385A Highland Colony Parkway, Suite 120 Ridgeland, MS 39157 Phone: 601-957-1575 x212 Fax: 601-956-1713	http://www.iqh.org
JSI Research and Training Institute, Inc.	44 Farnsworth Street Boston, MA 02210 Phone: 617-482-9485 Fax: 617-482-0617	http://www.jsi.com
Leade Health	320 Miller Avenue, Suite E Ann Arbor, MI 48103 Phone: 734-995-0699 Fax: 734-988-1011	http://www.leadehealth.com
Mayo Clinic Tobacco Quitline	4001 NW 41st Street Rochester, MN 55901-8901 Phone: 507-538-5078 Fax: 507-538-5081	http://www.mayoclinic.com
National Jewish Medical and Research Center	1400 Jackson Street Denver, CO 80206 Phone: (303) 398-1016 Fax: 303-270-2170	http://www.nationaljewish.org
Partners in Corporate Health, Inc.*	1191 Pineview Drive, Suite F Morgantown, WV 26505 Phone: 304-599-6981 Fax: 304-599-5507	http://www.ynotquit.com

[†] Information subject to change without notice.

* Indicates that this vendor is a for-profit organization.

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Note: This list is intended to serve as a directory of vendors known to CDC/OSH as of December 2003 and not as an endorsement for a particular vendor.[†]

Organization	Contact Information	Web Address
Providence Alaska Medical Center	3200 Providence Drive Anchorage, AK 99508 Phone: 907-261-4815 Fax: 907-261-6028	http://www.providence.org/alaska/default.htm
Roswell Park Cancer Institute, Department of Health Behavior	Elm & Carlton Streets Buffalo, New York 14263 Phone: 716-845-8817 Fax: 716-845-8487	http://www.roswellpark.org
University of Nevada, School of Medicine	6375 West Charleston Boulevard, Suite A100 Las Vegas, NV 89146 Phone: 1-888-866-6642 Fax: 702-877-2108	http://www.livingtobaccofree.com
University of California, San Diego, Department of Family and Preventive Medicine	9500 Gilman Drive, Mail Code 0905 La Jolla, CA 92093-0905 Phone: 858-300-1032 Fax: 858-300-1099	http://www.californiasmokershelpline.org
Wellplace (Pioneer Development and Support Services)*	7309 South 180 West Midville, UT 84047 Phone: 1-800-821-HELP	http://www.wellplace.com

[†] Information subject to change without notice.

* Indicates that this vendor is a for-profit organization.

Appendix C: Cessation Web Resources*

State Resources

State	Web Address
Arizona	www.ashline.org
California	www.californiasmokershelpline.org
Colorado	www.co.quitnet.com
Connecticut	www.ctquitline.org
Iowa	www.quitlineiowa.org
Maryland	www.smokingstopshere.com
Massachusetts	www.trytostop.org
Michigan	www.hpclearinghouse.org/tobacco/intobacco.html
New Jersey	www.nj.quitnet.com
New Mexico	www.thestink.org
New York	www.nysmokefree.com
Nevada	www.livingtobaccofree.com
Oregon	www.oregonquitline.org
Utah	www.tobaccofreeutah.org
Virginia	www.smokefreevirginia.org
Washington	www.quitline.com
West Virginia	www.ynotquit.com

Additional Resources

Organization	Web Address
American Cancer Society	www.cancer.org
Agency for Healthcare Research and Quality	www.ahrq.gov
American Legacy Foundation	www.americanlegacy.org
American Lung Association	www.lungusa.org/tobacco
Centers for Disease Control and Prevention	www.cdc.gov/tobacco/how2quit.htm
Center for Tobacco Cessation	www.ctcinfo.org
Office of the Surgeon General	www.surgeongeneral.gov/tobacco
National Cancer Institute	www.smokefree.gov
Smoke-Free Families	www.smokefreefamilies.org

* Web addresses subject to change without notice.

Appendix D: Client Education Materials Commonly Distributed by Quitlines^{†*}

Organization	Title of Publication	Contact
American Cancer Society	<ul style="list-style-type: none"> • Set Yourself Free • Make Yours a Fresh Start Family • Living Smoke-Free for You and Your Baby • Cold, Hard Facts About Quitting • Quitting Spitting • Break Away From the Pack • Quit the Spit 	1-800-227-2345 404-329-5783 http://www.cancer.org
American Legacy Foundation	<ul style="list-style-type: none"> • Great Start Information Packet (for pregnant and postpartum women) 	1-866-66-START http://www.americanlegacy.org
American Lung Association	<ul style="list-style-type: none"> • Quitting for Life • Quit Smoking Action Plan • Assorted Fact Sheets 	1-800-LUNG-USA http://www.lungusa.org
Centers for Disease Control and Prevention	<ul style="list-style-type: none"> • "I Quit!" • You Can Quit Smoking • Pathways to Freedom 	1-800-311-3435 http://www.cdc.gov/tobacco
ETR (Education Training Research)	<ul style="list-style-type: none"> • Before You Quit Smoking • Remaining a Former Smoker • Pregnancy and Smoking • Do You Want to Be a Former Smoker? • Quit Smoking for Good: The Decide Guide • Quitting Smoking for Good: The Take Control Guide • Butts Out, Volumes 1 and 2 	1-800-321-4407 http://www.etr.org
Journey Works	<ul style="list-style-type: none"> • Tobacco and Stress • Secondhand Smoke and Your New Baby 	1-800-775-1998 http://www.journeyworks.com
National Cancer Institute	<ul style="list-style-type: none"> • Spit Tobacco: A Guide for Quitting 	1-800-4-Cancer http://www.nci.nih.gov
New York State Smokers' Quitsite (Roswell Park)	<ul style="list-style-type: none"> • Break Loose: A Pack of Facts to Help You Stop Smoking Guide • Why Don't They Call Them What They Are? • Staying Tobacco-Free Guide • Various fact sheets 	1-888-609-6292 http://www.nysmokefree.com

† Numbers subject to change without notice.

* This list was developed from respondents' answers to a survey on state quitlines conducted by University of California, San Diego in spring 2002. Many other materials are available and utilized by state quitlines.

Appendix E: Sample Technical Review Instrument

Instructions

Your role as a reviewer is to evaluate the proposals with regard to the proposer's ability to (1) provide services for implementation and operation of a comprehensive tobacco use quitline, as outlined in the Description of Proposal Requirements and (2) approach the Scope of Work with an understanding of what was required in the RFP. Please complete one Technical Review Instrument (score sheet) for each proposal. The instrument has been divided into separate sections with specific questions pertaining to each category. Points should be assigned in the space following the question. A space for comments is available after each section of the review instrument. Please note that some sections ask for comments on a specific issue in addition to general comments. *(Note: the comments section has been omitted from this sample in order to conserve space in this document.)* Proposals should be rated on their own merit and not compared with other proposals you are reviewing.

This scoring form may be made available to a variety of interested parties after the review process is completed, so please bear this in mind when recording your comments on this document. Confine your comments to answering the review questions directly and specifically. Avoid general comments such as *great job, looks really good*, etc. It is important that you substantiate your comments directly from the proposal, e.g., *the proposer thoroughly demonstrates the capability to address low-literacy population needs by employing methodologies....*

After the reviewers have evaluated the proposals, we will meet to review and discuss each proposal as a group. At that time, you will be asked to share comments and assessments so the review panel can select the oral presentations. The finalist oral presentations will be scored separately. To complete the process, a final discussion will be held to select the vendor for “best and final” negotiations.

I. Description of Agency's Experience with Similar Projects	20 points
<p>1. Does the vendor have sufficient and appropriate experience and capability to work with governmental/nonprofit agencies? Does the vendor have experience with “800 line” operations? Does the vendor have experience with tobacco cessation counseling?</p> <p>2. Does the vendor have experience collaborating with diverse health systems and provider agencies?</p> <p>3. Does the vendor have sufficient expertise and experience with large agencies (e.g., state departments of health) to perform all aspects of the work?</p> <p>4. Does the vendor have sufficient and appropriate capability and experience in applying appropriate telephone and data collection technology?</p> <p>5. Does the vendor demonstrate sensitivity to religious, cultural, educational, and socioeconomic characteristics of potential clients?</p> <p>6. Are three references provided with the following: company name; project manager/other point of contact; address; telephone; fax; e-mail address of project manager/contact; title of project/campaign; date of contract?</p> <p><input type="checkbox"/> YES — <input type="checkbox"/> NO</p>	

† Note: Adapted from the Georgia Tobacco Use Prevention Section. The RFP developed by Georgia is available at <http://www.cdc.gov/tobacco>.

Appendix E: Sample Technical Review Instrument

II. Description of Organizational Capacity and Fiscal Stability 1. How well does this contract fit into the vendor's philosophy and/or mission? 2. Do organization chart and staff experience indicate sufficient capability to manage state quitline operations? 3. Does the vendor demonstrate sufficient fiscal, administrative, and experiential ability to manage a state government contract?	5 points
III. Work Plan for Proposed Approach and Coordination with State Health Department 1. Will it be realistic to update the proposed overall work plan within the designated time frame of the implementation requirements? 2. Is each deliverable of the work plan sufficiently detailed and congruent with the program in terms of scope, duration/milestone date, and "delivery, inspection, and acceptance" criteria? 3. Are the deliverables of the work plan reasonably tied to the proposed "progress payment schedule"? 4. Are sample deliverables provided?	20 points
IV. Proposed Funding Patterns for the Project—Costs 1. Does the vendor indicate a comprehensive set of program start-up costs/activities? 2. Do costs appear to be reasonable given required activity? 3. Is there sufficient explanation of budget requirements? 4. Does the vendor describe a comprehensive set of ongoing program cost components? 5. Do ongoing costs appear to be reasonable, given required activity? 6. Is there sufficient explanation of budget requirements?	15 points
V. System Capacity and Facilities 1. Are indicated space requirements sufficient to reasonably accommodate required staff? 2. Is record storage capability sufficient to ensure confidentiality? 3. Is the proposed telephone system state-of-the-art, and does it include capabilities required to effectively manage call volume and overall activity (strong communication server[s], up-to-date software, automatic call distribution functionality, telephony integration)? Are the percentage of calls answered live during operating hours and average length of time to a live answer acceptable? What is the voice mail capacity? 4. Do proposed "live" response hours meet the state's needs in terms of ensuring appropriate coverage? Is there a plan for handling calls after hours and during holidays? Does the rationale for response hours indicate understanding of issues and needs of quitline? Does the vendor indicate ability to adjust for peak volume periods? 5. Is proposed monitoring system capable of collecting information required to effectively administer operations, including demographic and utilization data identifying peak hours, call volume, etc.? Does the vendor indicate ability to effectively manage operations on day-to-day and long-term basis? 6. Does the methodology for estimating call volume appear reasonable and reflect understanding of operational requirements? 7. Does the vendor demonstrate flexibility and capability to adjust as operations mature (e.g., can they handle volume expansion)?	25 points
VI. Scientific Capacity/Service Delivery Protocol 1. Does the vendor describe service protocols that reflect the current science base for quitlines (e.g., PHS guidelines) and demonstrate the ability to effectively address a range of individual callers' needs? 2. Is the proposed approach comprehensive in its ability to provide appropriate motivational messages, cessation information, and referral information? 3. Does the vendor have access to a scientific advisory board? 4. Are caller follow-up protocols comprehensive, and is ongoing tracking sufficient for efficient and smooth transition to next steps? 5. Are there written procedures and policies for all aspects of operation?	25 points
VII. Follow-Up Counseling 1. Does the vendor indicate follow-up service protocols that reflect current "best practices" and ability to effectively address individual callers' needs? 2. Are the scheduling and follow-up tracking methodologies reasonable and reflective of current "best practices"?	15 points

Appendix E: Sample Technical Review Instrument

VIII. Tracking	15 points
<ol style="list-style-type: none"> 1. Does the vendor indicate effective and efficient operational tracking capability? Will capability effectively provide data/information required to monitor ongoing operations and long-term outcomes? 2. Does the vendor indicate effective policies/procedures to ensure record safekeeping and confidentiality? 3. Does the vendor indicate appropriate capability for disaster management and data protection? 4. Does the vendor describe a comprehensive plan to maintain a referral resource database and capability to link referral data to geographic location of caller? 5. Are tracking procedures in compliance with HIPAA? 	
IX. Development of Support Material	10 points
<ol style="list-style-type: none"> 1. How detailed and effective is the vendor's plan to develop and disseminate materials that address self-help techniques for both smoking and smokeless tobacco? 2. Does the vendor provide appropriate attention to the needs of low-literacy level audiences? 3. Is additional proposed support material of high quality? 	
X. Communication and Coordination with Statewide Media Campaign	10 points
<ol style="list-style-type: none"> 1. Does the vendor propose a comprehensive approach to coordination of activities with marketing contractor, including joint planning meetings and the provision of weekly volume reports? 2. Does the vendor indicate knowledge and understanding of requirements of quitline promotional campaigns? 	
XI. Outreach to Referral Sources	5 points
<ol style="list-style-type: none"> 1. Does the vendor propose a comprehensive and effective approach, including developing a database, to the identification and education of potential referral sources, such as public health clinics, private practitioners, etc.? 2. Does the vendor indicate commitment to assist in community education activities? 	
XII. Evaluation and Quality Improvement	15 points
<ol style="list-style-type: none"> 1. Does the vendor propose appropriate methodologies to measure and evaluate the reach and effectiveness of ongoing project activities (e.g., quit rate/satisfaction surveys)? 2. Does the vendor have well-established procedures for tracking, analyzing, evaluating, and adjusting program components and operations, including staff performance monitoring? 3. Does the vendor propose a clear and reasonable methodology for benchmarking performance for both project management and overall evaluation purposes? 4. Does the vendor propose a comprehensive quality assurance plan? 	
XIII. Proposed Organization and Staffing for Project and Staff Qualifications	20 points
<ol style="list-style-type: none"> 1. Does the organizational chart clearly indicate roles and responsibility of operational staff? 2. Are proposed roles, responsibilities, and staffing schedules appropriate to sufficiently service the quitline? 3. Does the vendor indicate commitment to this program by presenting qualified and highly capable staff? 4. Is the vendor assigning seasoned management to the program? 5. Are staff training procedures comprehensive and sufficient to assure up-to-date knowledge of subject matter? 6. Is there a clinical director on staff? 7. What is the staff-to-supervisor ratio? 	
XIV. Statement of Disclosure	no points
<ol style="list-style-type: none"> 1. Does vendor hold a current or past affiliation/contractual relationship with a tobacco company? <input type="checkbox"/> YES — <input type="checkbox"/> NO 2. Does the vendor hold a current or past affiliation/contractual relationship with a tobacco-related entity, such as owners, affiliates, subsidiaries, holding companies, or companies involved in any way in the production, processing, distribution, promotion, sale, or use of tobacco? <input type="checkbox"/> YES — <input type="checkbox"/> NO 	

Appendix E: Sample Technical Review Instrument

Technical Review Scoring Summary Page

Reviewer number: _____ Date reviewed: _____

Proposer's name: _____

SCORES	
Description of Agency's Experience with Similar Projects	20
Description of Organizational Capacity and Fiscal Stability	5
Work Plan for Proposed Approach/Coordination with State Health Department	20
Proposed Funding Patterns—Start-up Costs	15
System Capacity and Facilities	25
Scientific Capacity/Service Delivery Protocol	25
Follow-up Counseling	15
Tracking	15
Development of Support Material	10
Communication/Coordination with Media Campaign	10
Outreach to Referral Sources	5
Evaluation/Quality Improvement	15
Proposed Organization/Project Staffing/Staff Qualifications	20
Statement of Disclosure	Y/N
Written Proposal Total Score	200

Summary comments: _____

Summary strengths and weaknesses:

Minor concerns that could be addressed in negotiations:

† Note: Adapted from the Georgia Tobacco Use Prevention Section. The RFP developed by Georgia is available at <http://www.cdc.gov/tobacco>.

Appendix F: Proposed Minimal Data Set for Evaluation of Telephone Cessation Helplines/Quitlines[†]

Background

The following Minimum Data Set was developed by the North American Quitline Consortium in conjunction with Canadian partners (Health Canada and the Centre for Behavioural Research in Program Evaluation, University of Waterloo). It provides a mechanism to facilitate performance monitoring, would make comparisons possible, would be feasible, and would not impose undue burdens on quitlines. Potential funders, quitlines, scientists, vendors, and researchers have provided input to the process.

A. Recommendation for Standard Description

Quitline services are provided in many forms; for this reason, the evaluation needs to be flexible to account for the variations. When reporting on quitlines, the following elements should be described:

Minimal Descriptors

1. Overall quitline objectives (including target population).
2. Service delivery model. *A checklist could be developed to describe the types of services provided. Best-practice elements (e.g., crisis intervention protocols) should be identified and included in the above checklist.*

Additional Helpful Descriptors

1. Contextual setting (tobacco prevalence; population demographics; economic, social, and policy environment).
2. Role of quitline in comprehensive tobacco control strategy.

B. Recommendations for Minimal Data Set

The table below identifies the recommended set of indicators to be collected in a consistent manner by all quitlines. It is also recommended that both a short-term and a long-term follow-up evaluation be conducted. The short-term evaluation will help identify immediate impacts of the quitline service (particularly actions taken as a result of the quitline call), whereas the long-term follow-up evaluation will provide measures of quitline effectiveness. A 30-day and a 6-month follow-up period were recommended for the minimal data set.

Per Society for Research on Nicotine and Tobacco (SRNT) recommendations, the follow-up period is scheduled based on the ***first call at which the person receives counseling***. Since quitline services vary, both the service and the time at which counseling is received by the caller should be well described so that readers can determine if comparisons across quitlines or over time can be made.

Data will be collected from three different sources:

- Administrative files.
- The intake call with those who call the quitline.
- Short- and long-term follow-up calls to evaluate service outcomes.

[†] Developed by the Centre for Behavioural Research and Program Evaluation, University of Waterloo in collaboration with the North American Quitline Consortium, with funding from Health Canada and the Canadian Cancer Society. May 2004.

Appendix F: Proposed Minimal Data Set for Evaluation of Telephone Cessation Helplines/Quitlines

INDICATORS TO BE COLLECTED AT INTAKE			
Evaluation Goal	Indicators	Questions	Comments
Caller Characteristics	Sex	First, I need to verify: are you male or female?	
	Age	What is your date of birth? (month, year)?	
	Pregnancy	Are you currently pregnant?	
	USA Ethnic background questions	Are you Hispanic or Latino? (yes, no, refused, don't know) Which one of these groups would you say best represents your race? 1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 6. Other (specify) _____ 7. Don't Know 8. Refused?	These questions are then recoded into various race/ethnicity combinations depending on one race or more being specified, etc.
	CANADIAN Ethnic background questions	To which ethnic or cultural group(s) did your ancestors belong?	Can be categorized as follows: 1. Canadian 2. English, Irish, Scottish, Welsh 3. Asian 4. Aboriginal (Native Indian, Inuit, Metis) 5. European 6. Other (specify) 7. Don't Know 8. Refused?
	Education	What is the highest level of education you have completed? (person states actual education level and interviewer categorizes)	Less than grade 9, grade 9–11 no degree, GED, high school degree, some college, college or university degree
	Health insurance	What is the name of your health insurance carrier?	Name _____ or Not insured
	Geographic region (postal/ZIP code)	What is your postal code or ZIP code?	

Appendix F: Proposed Minimal Data Set for Evaluation of Telephone Cessation Helplines/Quitlines

INDICATORS TO BE COLLECTED AT INTAKE			
Evaluation Goal	Indicators	Questions	Comments
Tobacco Behaviors	Tobacco use status <i>Series of questions to determine all forms of tobacco use</i>	1. Do you currently smoke cigarettes every day, some days, or not at all? 2. Do you currently use any other tobacco products? (yes, no) 3a. If yes, do you currently smoke cigars (every day, some days, not at all?) 3b. If yes—do you currently use chewing tobacco or snuff (every day, some days, not at all?)	Canada: Use national survey response options: daily, occasionally, not at all?
	Smoking intensity <i>Amount of tobacco smoked or chewed</i>	How many cigarettes do you smoke per day? How many cigars do you smoke per day? How many pouches or tins do you use per day?	These questions to follow immediately after asking if they currently use cigarettes, cigars, or chewing tobacco.
Explanatory Factors (shown to be predictive in cessation success)	Level of addiction	How soon after you wake do you smoke your first cigarette? (within first 5 min; 6 to 30 min; 31 to 60 min; more than 60 min.)	
	Self-efficacy	On a scale of 1 to 5, with 1 being not at all confident, how confident are you that you will not be smoking a year from now?	
Effectiveness of Promotion	Awareness of quitline	How did you hear about the quitline? (Media—radio, TV, newspapers Other Advertising—phone book Referrals—health professionals, workplaces, insurance)	Code all sources, but when reporting, categorize as media, other advertising and referrals.

Appendix F: Proposed Minimal Data Set for Evaluation of Telephone Cessation Helplines/Quitlines

INDICATORS TO BE COLLECTED AT FOLLOW-UP			
Evaluation Goal	Indicators	Questions	Comments
Service Delivery	Client satisfaction	Overall, how satisfied were you with the quitline? (very, mostly, somewhat, not at all?)	
	OPTIONAL QUESTION Extended benefit from quitline	Did you share the information you received from the quitline with anyone else? (yes, no)	
Impact Recommend 1 month grace period after FIRST call to the quitline in order for caller to complete counselling and/or set a quit date. Follow-up evaluation call to be conducted 7 months after FIRST call to quitline.			
Change in Smoking Behaviors	Tobacco use status	1. Do you currently smoke cigarettes every day, some days, or not at all? 2. Do you currently use any other tobacco products? (yes, no) 3a. If yes, do you currently smoke cigars (every day, some days, not at all?) 3b. If yes—do you currently use chewing tobacco or snuff (every day, some days, not at all?)	Canada: Use national survey response options: daily, occasionally, not at all?
	Switch from one form of tobacco to another	Use above questions regarding the types of tobacco used at intake and at follow-up.	Calculate whether switched forms of tobacco between initial call and follow-up.
	OPTIONAL Smoking intensity Determine reduction in amount smoked or chewed	How many cigarettes do you smoke per day? How many cigars do you smoke per day? How many pouches or tins do you use per day?	Reduction in amount smoked may be of interest to funders, but is not associated with health benefits nor increased success in quitting.
	Level of addiction	How soon after you wake do you smoke your first cigarette? within first 5 min; 6 to 30 min; 31 to 60 min; more than 60 min.	
Actions Taken as Result of Call			
	Quit attempts	Since you first called the quitline on (date), were you able to quit using tobacco for 24 hours or longer? (yes, no, refused, don't know)	
	OPTIONAL Length of time smoke-free	What is the longest time you went without using tobacco, even a puff or pinch?	Record in days—less than 24 hours would not qualify as a quit attempt.

Appendix F: Proposed Minimal Data Set for Evaluation of Telephone Cessation Helplines/Quitlines

INDICATORS TO BE COLLECTED AT FOLLOW-UP			
Evaluation Goal	Indicators	Questions	Comments
Quit Rates	7-day point prevalence	Have you smoked any cigarettes, even a puff, in the last 7 days?	
	30-day point prevalence	Have you smoked any cigarettes, even a puff, in the last 30 days?	
	6-month prolonged abstinence (allows for relapse of less than 7 days and not more than 2 weeks over 6 months). <i>Note: Requires two questions</i>	Since your first call to the quitline 6 months ago, was there ever a time when you smoked for 7 days in a row (7 consecutive days)? Since your first call to the quitline 6 months ago, was there ever a time when you smoked at least on the weekend for 2 weekends in a row (2 consecutive weeks)?	

INDICATORS TO BE DETERMINED FROM ADMINISTRATIVE DATA			
Evaluation Goal	Indicators	Questions	Comments
Utilization	Call volume	Total number of calls answered per (month, year).	Would be helpful to record the total number of calls, answered and unanswered.
Services Delivered	Counselling sessions delivered	Total number of callers who received at least one counselling session (reactive). Total number of callers who received more than one counselling session (proactive).	Some quitlines screen callers, then refer to a counsellor. Others provide counselling on the first call. We are interested in the number who receive counselling, not just screening.
Reach	Proportion of target population who contact the quitline	Number of individuals who contact the quitline divided by the number of [adult] smokers in the target population. Where total number in the target population is unknown, population surveys can be used.	Target population will be defined by the goals of the service (e.g., serve only smokers or smokers plus others). This should be captured by following the recommended standard description.
Costs	Most common is cost per call, including and excluding promotion costs.		Canadian investigators currently working on possible estimates of cost benefit.

Appendix G: Health Insurance Portability and Accountability Act (HIPAA)

Privacy Rule Highlights for Tobacco Quitlines

Does the Privacy Rule permit covered entity providers to disclose protected health information to a quitline without patient authorization in order to refer that patient for the quitlines services?

If a quitline is considered a health care provider under the privacy rule, a referral for treatment purposes would be permissible without patient authorization.

Does it matter whether the referral is provided by fax, phone, or otherwise?

No.

Are quitlines covered entities under the Privacy Rule?

Quitline providers may be covered entities under the Privacy Rule if they meet the definitions in the rule or are part of a larger entity that is a health care provider that conducts covered electronic transactions, a health plan, or health care clearinghouse that has not elected hybrid entity status. See the Centers for Medicare and Medicaid Services Web site decision tool for more information: <http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp>.

For the Privacy Rule requirements for covered entities, please consult the U.S. Department of Health and Human Services, Office for Civil Rights Web site at <http://www.hhs.gov/ocr/hipaa>.

Does the Privacy Rule preempt state laws that might apply to quitlines?

The HIPAA Privacy Rule provides a federal floor of privacy protections for individuals' individually identifiable health information where that information is held by a covered entity or by a business associate of the covered entity. State laws that are contrary to the Privacy Rule are preempted by the federal requirements, unless a specific exception applies. These exceptions include if the State law (1) relates to the privacy of individually identifiable health information and provides greater privacy protections or privacy rights with respect to such information, (2) provides for the reporting of disease or injury, child abuse, birth, or death, or for public health surveillance, investigation, or intervention, or (3) requires certain health plan reporting, such as for management or financial audits. In these circumstances, a covered entity is not required to comply with a contrary provision of the Privacy Rule.

HIPAA Web Information Sources

General Privacy Rule fact sheet:

<http://www.hhs.gov/news/facts/privacy.html>

Additional information on the Privacy Rule:

<http://answers.hhs.gov/>. Select Privacy of Health Information from the Category menu and HIPPA type in the Search Text box for specific topics, such as “referral for treatment” or “who must comply.”

Tobacco Treatment Enrollment

Tobacco Treatment Checklist

AD VISE smoker to stop: ☐ Stop-smoking advice given. If strongly advise you to quit smoking and help you.”

ASSESS readiness to quit: ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

ASSIST smoker to quit:

☐ Brief counseling

Reasons to quit Barriers to quitting Lessons from past quit attempts Set a quit date, if ready Enlist social support

☐ Medications if appropriate

Nicotine Replacement (NRT): patch gum lozenge inhaler nasal spray Other (CIRCLE): Bupropion (Zyban/Wellbutrin SR)

ARRANGE follow-up: ☐ Refer to Try-To-STOP TOBACCO Resource Center by faxing the lower part of this form toll-free to 1-866-560-9113

Massachusetts Resident Enrollment Form

Fax this part of form to 1-866-560-9113

PRIMARY CARE PROVIDER				
primary care provider or specialist name		UPIN# (OPTIONAL)	phone (area code + number) ()	fax (area code + number) ()
primary care provider or specialist address		city	state	zip
PATIENT				
first name		last name		date of birth (month/day/year)
phone (area code + number) ()	May we leave a message? <input type="checkbox"/> yes <input type="checkbox"/> no	language preference (circle): English Spanish other (specify):	email address	
patient address		city	state	zip
insurance <input type="checkbox"/> BCBSMA <input type="checkbox"/> BMC HealthNet Plan <input type="checkbox"/> Fallon <input type="checkbox"/> Harvard Pilgrim <input type="checkbox"/> MassHealth <input type="checkbox"/> Neighborhood Health Plan (NHP) <input type="checkbox"/> Network Health <input type="checkbox"/> Tufts Health Plan <input type="checkbox"/> Other_____				
The Resource Center usually calls the patient within three business days of receiving a referral. When should we call?				
circle all that apply:	morning	afternoon	evening	no preference

I, _____, hereby authorize Try-To-STOP TOBACCO Resource Center of Massachusetts, (the "Resource Center"), and its representatives to disclose information about me to:

- 1) the American Cancer Society Quitline to the extent necessary to allow me to participate in its tobacco cessation counseling program; and
- 2) my primary care provider or other provider ("Provider") I designate to the Resource Center to the extent the Resource Center deems necessary to give my Provider an update of my progress in attempting to stop smoking.

I authorize NSMC to release the information on this enrollment form to the Resource Center for purposes of my participation in the QuitWorks program. I also authorize the Resource Center and its representatives to contact me upon receiving this referral from NSMC.

SIGNATURE OF THE PATIENT OR PATIENT'S REPRESENTATIVE

DATE _____

PRINTED NAME OF PATIENT REPRESENTATIVE _____

RELATIONSHIP TO PATIENT

5/03

File in chart behind Smoking Questionnaire

QUITWORKSSM

Quick Guide To Pharmacotherapy In Tobacco Treatment

NICOTINE REPLACEMENT OPTIONS

PATCHES

Nicotrol [®] 15 mg	Initial: MAX:	1 patch/16 hrs. Same as above	Treatment Duration: 8 wks.
* Nicoderm [®] CQ 21 mg 14 mg 7 mg	Initial: MAX:	1 patch/24 hrs. Same as above	Treatment Duration: 8 wks.

GUM

Nicorette [®] 2 mg 4 mg	Initial: MAX:	1 piece every 1–2 hrs. 24 pieces/24 hrs.	Treatment Duration: 8–12 wks.
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LOZENGE

Commit [®] 2 mg 4 mg		1 lozenge/1–2 hrs. (wks 1–6) 1 lozenge/2–4 hrs. (wks 7–9) 1 lozenge/4–8 hrs. (wks 10–12)	Treatment Duration: 12 wks.
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NASAL SPRAY

Nicotrol [®] NS 10 mg/ml	Initial: MAX:	1–2 doses/hr. 5 doses/hr. or 40 doses/day	Treatment Duration: 3–6 mos.
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INHALER

Nicotrol [®] Inhaler 10 mg/cartridge	Initial: MAX:	6–16 cartridges/day 16 cartridges/day	Treatment Duration: 3–6 mos.
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NON-NICOTINE MEDICATION

BUPROPION HCL SR

* Zyban [®] 150 mg tablets	Initial: MAX:	150 mg/day (days 1–3) 300 mg/day (day 4+) 300 mg/day	Treatment Duration: 7–12 wks.
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Inclusion of this adult dosage chart is strictly for the convenience of the prescribing provider. Please consult the Physicians' Desk Reference for complete product information and contraindications. This chart does not indicate or authorize insurance benefit coverage for any of these medications. For insurance benefit information, the patient will need to contact his/her insurer directly. The cost or provision of these medications is not included as any part of the Ty-To-STOP TOBACCO Resource Center of Massachusetts or QuitWorks program.

* NORMALLY AVAILABLE FROM HOSPITAL PHARMACY

Make smoking history.



Tobacco Quitlines

at a glance

What are tobacco quitlines?

Quitlines are telephone-based tobacco cessation services. Since the late 1980's, quitlines have been established in many countries, states and provinces. Most are accessed through a toll-free telephone number and provide a combination of services including educational materials, referral to local programs, and individualized telephone counseling. Counselors answer callers' questions about the cessation process and help them develop an effective plan for quitting.

Reactive quitlines only respond to incoming calls. Proactive quitlines handle incoming calls and also follow up the initial contact with additional outbound calls, to help initiate a quit attempt or to help prevent relapse. In some cases, as when smokers give consent in their doctors' offices to be called by a counselor, the contact is entirely proactive. Proactive telephone counseling has been shown to have a marked effect on callers' probability of success in quitting and in maintaining long-term abstinence from tobacco use, comparable to the effects of pharmacotherapies.

Where are they available?

Brazil, Iran, New Zealand, South Africa, many European countries, some countries in Asia, and most Australian,

Canadian, and U.S. states and provinces have publicly financed quitlines. Some employers and private health insurers provide quitlines for their employees and members. Many new quitlines have been set up in recent years, as evidence of their efficacy has become more solid and as tobacco control programs worldwide have become more common. Quitlines vary greatly in scale and sophistication.

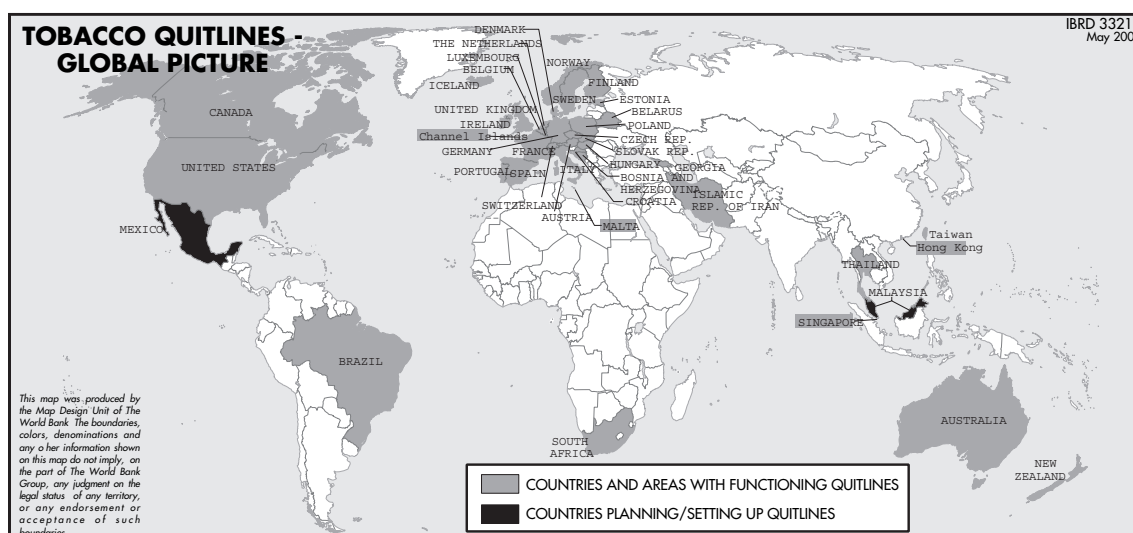
Why have quitlines become popular?

Easy access. Traditionally, tobacco users have faced various barriers in accessing cessation services, including:

- Sporadic availability, geographically and over time
- Transportation difficulties
- Childcare responsibilities
- Financial cost of participating.

Quitlines reduce these barriers by allowing users to access service from their own homes at a time that is convenient for them, and usually at no cost to themselves. Partly for these reasons, surveys have shown that tobacco users are much more likely to use telephone-based services than face-to-face programs.

Benefits of centralization. Because it provides services over the telephone, a quitline can serve a large geographic



May 2004

area from a single, centralized base of operations. So unlike traditional cessation programs in which it is common for participants to have to wait until a group forms, quitlines are able to operate year-round, often with extended hours of business and multilingual capabilities.

The benefits of centralization include:

- Economies of scale, leading to more efficient utilization of counseling resources
- Standardized training
- Better quality control
- Ease of evaluation.

Ease of promotion. Most comprehensive tobacco control programs include a media component designed to counteract the effects of tobacco industry advertising. This key part of successful anti-tobacco programs can be very costly, necessitating prudent spending decisions. Media programs are a convenient way to promote cessation services, since advertisements can carry a single telephone number and air across a wide area. This is more efficient than promoting an array of local programs, each with its own method of accessing service. And quitlines can refer callers to local programs as appropriate, thus serving both as a direct cessation service provider and as a hub of coordinated services.

Strong evidence of quitline efficacy

Reactive quitlines: Two studies support use of a reactive quitline in the context of a comprehensive tobacco control program. A California study found that a well-promoted quitline providing a single comprehensive counseling session of about 50 minutes increased quit attempts and reduced relapse, relative to an intervention of self-help materials alone (Zhu et al. 1996). Counties in New York State where a quitline was promoted had significantly higher quit rates than those without such promotion, even though the majority of evaluated quitters did not access the service, indicating that quitline promotion in itself may increase cessation on a population level (Ossip-Klein et al. 1991).

Proactive quitlines: The evidence for proactive quitlines is more thorough. Several meta-analytical reviews have established that proactive telephone counseling is an effective intervention for smoking cessation (Lichtenstein et al. 1996, Fiore et al. 2000, Hopkins et al. 2001, Stead et al. 2004). The most recent of these examined 13 studies of proactive interventions and found that callers who received counseling were successful at least 50% more often than those who only received self-help materials (odds ratio of 1.56) (Stead et al. 2004). The *U.S. Public Health Clinical Practice Guideline* and the *Guide to Community Preventive Services* recommend proactive quitlines as a way to help smokers quit (Fiore et al. 2000, Hopkins et al. 2001).

A large randomized, controlled trial (n=3,030) that served as the basis for the California Smokers' Helpline, the first publicly supported, statewide quitline, found that telephone counseling increased the percentage of smokers making a quit attempt and decreased the rate of relapse for those

attempts, and found a strong dose-response relationship between the level of intended treatment intensity (i.e., number of follow-up sessions) and the treatment effect (Zhu et al. 1996).

Further research has demonstrated the continued effectiveness of the California quitline after it scaled up to statewide operation (Zhu et al. 2002). Borland et al. (2001) found similar results for a quitline service in Victoria, Australia. These studies increase confidence that the efficacy found in clinical trials can carry over to "real world" settings. With the efficiencies inherent in centralized, telephone-based operations, quitlines appear to be a cost-effective way to deliver cessation assistance (McAlister et al. 2004).

Quitlines as part of comprehensive tobacco control programs

Most quitlines are supported by state or national health agencies, through tobacco taxes or other public funds. They are often the government's chief or only contribution to providing direct tobacco cessation services, with the rest of its tobacco control funding earmarked for other efforts such as educating people about the harm caused by tobacco use, preventing initiation of tobacco use among young people, and reducing exposure to second hand smoke. If resources were not available to make progress in these areas, it is doubtful that a quitline alone would be a worthwhile investment of public health funds. But in the context of comprehensive tobacco control efforts, a quitline can help to advance larger goals of the program, such as normalizing cessation and eliminating disparities in tobacco use or access to treatment.

Practical considerations

The range of services provided: Quitline callers have a wide range of expectations, so most well established quitlines offer a wide range of services. Adult smokers wanting help to quit are the most common callers, but there are also those who are not yet ready to quit, or who have already quit. There are smokers of cigarettes, cigars, and pipes, and callers who use chewing tobacco or other smokeless tobacco. There are callers of all ages, including minors, and callers who speak different languages. In all of these categories, some want counseling; others just want printed information or referral. Some callers have particular needs such as learning more about smoking while pregnant, or quitting tobacco while managing a psychological condition such as bipolar disorder or schizophrenia. There are non-tobacco-users calling on behalf of friends and family members, and health care professionals or others trying to decide whether to refer their patients, students, or neighbors. Comprehensive quitlines develop protocols, resources, and staff training for each situation.

Evidence-based structured protocols guide the flow of counseling sessions and remind counselors of topics considered to affect quitting success. Counselors using clinically validated protocols help clients to:

- Clarify and enhance their motivation to quit
- Boost their self-efficacy for quitting
- Identify situations that will trigger an urge to use tobacco, and plan effective strategies for getting through them without tobacco
- Identify ways to get the social support they need
- Commit to a quit date, often with counselor follow-up for accountability and extra support.

Staffing: Quitlines are staffed to meet demand, which is largely determined by the intensity and timing of promotion. Rather than staying open around the clock, most quitlines focus their resources on peak daytime and evening hours. The staffing plan must take into account both the overall demand for service over time, and the demand at any given moment, especially during the “bursts” of calls that occur when mass media advertisements are aired. For new quitlines, the number of staff required may be calculated by estimating the likely number of callers, which in turn may be done by comparing the promotional plan with similar campaigns elsewhere. Most quitlines require between 30 minutes and two hours of counselor time per caller, depending on the intensity and number of counseling sessions provided. Maintaining a balance between counselors’ productivity and their availability for incoming calls is one of the main challenges of quitline operations, but one which becomes more manageable as the scale grows.

When recruiting counselors, it is helpful to keep in mind that most of the evidence for the efficacy of quitlines is based on the work of paraprofessional counselors using structured protocols, indicating that postgraduate education and licensure are not necessary. Instead of graduate training, most quitlines look for candidates with natural counseling skills such as empathy, reflective listening, and the ability to guide clients through a structured problem-solving process. These skills are crucial to quitline quality and effectiveness.

Training and supervision: A quitline’s training program is another key to assuring quality in its services. At a minimum, a good training program addresses:

- The psychology of tobacco use and the process of habit formation, maintenance, and extinction
- General principles of counseling and motivational interviewing
- Effective counseling techniques for behavior modification
- Challenging counseling scenarios, such as crisis calls and callers with psychiatric issues
- Multicultural counseling
- Effective case management practices, including use of protocols
- Health issues related to tobacco use and cessation
- NRT and other quitting aids.

Following up the initial training with a regular program of continuing education helps counselors continuously develop their skills and ensures that their knowledge of the field is up to date.

Besides providing training, quitline supervisors and managers oversee coverage of incoming calls, effective case management, and productivity. They monitor and debrief sessions and make sure the services provided are helpful, appropriate, and factually accurate. They also ensure the program’s compliance with applicable laws and ethical guidelines governing the provision of telephone counseling.

Evaluation: Successful and sustainable quitline operation requires rigorous evaluation. Baseline data include, at a minimum, how callers heard about the quitline, demographic variables such as age, ethnicity, and education, type of tobacco used and level of consumption. Process data include percentage of calls answered live and number of callers (especially members of target populations) receiving each type of service. Follow-up data include quit status, length of abstinence, and satisfaction with quitline services. For quitlines serving large numbers of callers, following up a randomly selected sample is adequate.

It may not be feasible or even desirable for every quitline to conduct its own clinical trial to ensure efficacy, but all quitline funding should include an allocation for program evaluation to address key questions:

- What contribution is the quitline making to the overall tobacco control program?
- Is it successful in reaching target populations, especially high-risk and underserved groups?
- Are callers satisfied with services received?
- What percentages of callers make a quit attempt, and maintain abstinence (e.g., for 6 months)?
- Are the results comparable to other published outcomes?

It is important when citing results to identify clearly any characteristics of the population that received service that may have had a bearing on their success, and to address whether and why any participants were excluded from the analysis.

Promotion: Increasing public awareness of quitline services can be done in various ways. Mass media advertising—television, radio, newspapers, billboards, and other media—usually plays a central role in promotion. Successful mass media campaigns identify their target audience and do thorough marketing research before launching ads. Cultural and linguistic appropriateness is especially important. Low-cost promotional strategies have been successfully used in some countries, such as requiring manufacturers to print the quitline telephone number on cigarette packages.

Health care providers are natural partners for quitlines and can play a major role in increasing their utilization. Providers who ask all patients whether they use tobacco, advise quitting, and refer patients to quitlines for comprehensive cessation counseling can have a profound impact on patient health. Therefore many quitlines make special efforts to build linkages with health care providers. As with mass media advertising, promoting quitlines through health care systems not only generates calls and

helps callers quit, but also increases cessation among people who do not call the quitline.

Technology: A robust and scalable telephone system greatly facilitates operations by allowing quitlines to:

- Queue calls and route them to counselors according to pre-established priorities
- Monitor calls
- Track and report on performance (e.g., percentage of calls answered live)
- Expand capacity as needed.

Information systems are very important to the smooth functioning of proactive quitlines, which over time may serve hundreds of thousands of callers, each receiving service spread out over several calls, in some cases with different counselors. Computer networks and databases must be able to store sufficient information on all contacts with individual callers to ensure a seamless delivery of services. Integration of the communication and information systems, using off-the-shelf Computer Telephony Integration (CTI) software, can greatly enhance efficiency. Other technologies have the potential to expand the range of services offered. Interactive Voice Response (IVR) systems, for example, allow callers to access personalized automated messages based on information they provide. Other emerging options include web-based interfaces, integration with email, and sending text messages or even images and short films to cell phone users.

Costs: The costs of establishing and running a quitline can vary widely. Communications and information systems can be a significant start-up cost, although fairly inexpensive options with limited functionality are available. The two largest ongoing expenses are usually for promotion and staffing. The U.S. Centers for Disease Control and Prevention recommend that new quitlines spend as much money on promotion in the first couple of years as on all other direct costs combined. (Quitline promotion, it should be remembered, not only generates calls to the quitline but also promotes cessation in the general population.) Over time, the cost for promotion may stabilize or even decrease as the quitline builds referral relationships with organizations and individuals in the community. Staffing costs, on the other hand, tend to increase steadily over the years.

Steps in setting up a quitline

- Assess the need for cessation services in the population, considering the prevalence of tobacco use in various communities and their readiness to respond to cessation messaging.
- Determine how direct provision of service fits into the overall plan for decreasing tobacco use in the population.

- Identify a reliable funding source and determine a funding level appropriate to the quitline's intended role in the overall tobacco control program. Tobacco taxes, where available, are a commonly used resource for quitlines.
- Determine a budget and strategies for promotion. Promotional budgets that are roughly equivalent to operational budgets are common.
- Create a competitive process to select a quitline operator. A Request for Proposals (RFP) process, in which the funding agency provides a thorough description of the quitline services to be provided and invites proposals from interested parties, is common.
- Create a similar process for selecting a media contractor. Require both contractors to coordinate their activities with each other.
- Write contracts with the selected providers that include firm deadlines for delivery of service.
- Closely monitor the contracts to ensure adherence to standards and deadlines. Perform ongoing evaluation to ensure the quitline's effectiveness and continued relevance to the overall tobacco control program.

Careful planning, an adequate budget, and rigorous evaluation will help ensure a successful quitline.

Key Resources for More Information

Anderson CM, Zhu SH. *The California Smokers' Helpline: A Case Study*. Sacramento, CA: California Department of Health Services; May 2000.

Borland R, Segan CJ, Livingston PM, Owen N. The effectiveness of callback counselling for smoking cessation: a randomized trial. *Addiction*. 2001;96:881-889.

Centers for Disease Control and Prevention. *Quitline Resource Guide: Strategies for Effective Development, Implementation, and Evaluation*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

European Network of Quitlines: Guide to Best Practice. Available at www.enqonline.org.

Lichtenstein E, Glasgow RE, Lando HA, Ossip-Klein DJ, Boles SM. Telephone counseling for smoking cessation: rationales and meta-analytic review of evidence. *Health Education Research: Theory and Practice* 1996;1:243-257.

Stead LF, Lancaster T, Perera R. Telephone counselling for smoking cessation (Cochrane Review). In: *The Cochrane Library* Issue 2, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Zhu SH, Anderson CM, Tedeschi GT, Rosbrook B, Johnson CE, Byrd M, Gutiérrez-Terrell E. Evidence of real-world effectiveness of a telephone quitline for smokers. *New England Journal of Medicine* 2002;347(14):1087-1093.

Zhu SH, Stretch V, Balabanis M, Rosbrook B, Sadler G, Pierce JP. Telephone counseling for smoking cessation: effects of single-session and multiple-session intervention. *Journal of Consulting and Clinical Psychology* 1996;64:202-211.

Expanded versions of the "at a glance" series, with e-linkages to resources and more information, are available on the World Bank Health-Nutrition-Population web site: www.worldbank.org/hnp

